Generic to Brand Authorization Form

COMPLETE AND SUBMIT THIS FORM ONLY IF A GENERIC EQUIVALENT IS AVAILABLE FOR YOUR PRESCRIPTION DRUG. CONSULT YOUR PHARMACIST.

A separate claim fonn must be used for each medication and each member.
This fonn must be completed by ordering physician and must be legible before review.

Patient Information

First Name _____ Middle Initial Last Name

Address _____

City _____ State _____ Zip Code _____

Phone ( ) _____ PatientDateofBirth_____ Sex _____

Patient SSN _____ Policyholder SSN _____

Physician Information

Prescribing M.D. _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____

Prescribed Drug Name: _____

Strength:

Dosage

Milligram	Gram
Teaspoon	Tablespoon
Ounce	Milliliter
Pint	Microgram
Cubic Centimeter	Other _____

Frequency (per day) _____ Other _____

Route of Administration

Tablet	Injection
Capsule	Liquid
Topical	Other _____
Suppository	

. Medical necessity:

Is it medically necessary for the Brand Name drug to be dispensed?

No Yes

Please check all that apply.

Past use of the generic drug has caused:

Seizures	Mood / Mental Changes
Loss of Consciousness	Allergic Reaction
Not Effective	Other

_____

Explain the medical necessity _____

Physician Signature _____ Date _____.,20 __

DEA#

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Revised 03/01/11